



# VILLAGE EMERGENCY CENTERS

## SIGN-IN SHEET

Thank you for choosing our emergency center at this critical time for you.  
Please complete the information below. All information is confidential.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender: ( ) Male ( ) Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

### How did you hear about us?

- Sports Physical  
  Flu Shot  
  E-mail  
  Internet Search  
  Friends/Family Recommendation  
 Driving by  
  Word of Mouth  
  Other: \_\_\_\_\_

WHAT IS THE NATURE OF YOUR EMERGENCY OR SYMPTOMS?

### Insurance Information

Primary Insurance \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

This Village Emergency Centers location is a free-standing emergency room. Texas insurance law provides that all fully-funded insurance plans should pay all emergency claims at "in-network" rates. At the time of your visit, the emergency room co-pay will be collected and your insurance carrier will be billed for your policy's emergency room benefits.

Auto Accident Information \_\_\_\_\_

Workman's Compensation Information \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_